Report on Focus Groups with Rhode Island Physicians on Implementing Clinical Best Practices

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May 27, 2004

Introduction

In order to inform strategies for ensuring the routine implementation and teaching of best practices in clinical medicine, the Rhode Island Department of Health (HEALTH), Quality Partners of Rhode Island, and the Office of Medical Faculty Affairs of Brown Medical School commissioned a pilot focus group study. The study, conducted by HEALTH's social marketing vendor PSI, explored barriers that physicians face in implementing and teaching best practices.

Research findings, presented in this report, provide insight on a variety of barriers that Rhode Island physicians face in implementing and teaching best practices in clinical medicine. Discussions in the two focus groups centered around two clinical practices – breast cancer screening and tobacco cessation. Further research should be undertaken to look at barriers associated with implementing and teaching best practices around other types of clinical practices.

Methodology

Physicians were recruited to participate in the groups by telephone—using lists from the Rhode Island Chapter of the American College of Physicians, RI Community Health Centers and family practices in Rhode Island.

PSI developed a moderator's guide (see Appendix A) and conducted the groups in April 2004. Each group lasted approximately seventy-five minutes. The focus groups were segmented: one group comprised of salaried physicians (i.e., employed by health centers or hospitals), and the other group comprised of non-salaried physicians (i.e., in private practice). In addition, participants were screened so that each focus group represented a balanced mix of gender and amount of time in practice (one to seven years in practice; or more than seven years in practice). Physicians who participated in the focus groups had specialties in internal medicine, general practice or family practice, and some had sub-specialties.

The composition of the groups was as follows:

Group	**Number of participants**
Salaried physicians	7
Non-salaried physicians	5

Physicians were paid a stipend of $150 to participate in the focus group.

For the purpose of the focus groups, discussion of "best practices" refers to evidence-based clinical practices. The terms "best practices" and "clinical guidelines" were used interchangeably throughout the focus groups.

Executive Summary

Clinical best practices, or guidelines, are helpful to physicians for many reasons. They serve as a mechanism for staying updated. They provide an overview of current research, and some physicians feel that trusted guidelines help improve patient care.

Physicians expressed differing views on the organizations that they trust to develop guidelines. Some prefer their professional organizations, while others prefer "experts" in the fields. When physicians receive guidelines, however, most want to know that credentialed people developed the guidelines using sound science. Additionally, physicians suggested that materials presented to them on best practices contain:

- A concise overview of the scientific method used to develop the guidelines;
- Information on the impact that the recommended practice has on patient outcomes; and
- "Tiered" measurement of the recommendations so they can prioritize which practices to implement if they cannot implement all of them.

Physicians prefer to receive information on guidelines via email or fax. A few want hard copies of documents they can file away and refer to when necessary. Some also like accessing information from websites if the information is well organized and up-to-date.

Barriers to implementing best practices, however, are plentiful. This study focused primarily on barriers related to two preventive health issues – breast cancer screening and smoking cessation. Following is a list of barriers that surfaced during discussions on each topic:

<u>Breast Cancer Screening:</u>

- Lack of consensus on guidelines,
- Lack of data linking the use of the guideline to improved health outcomes,
- Poor patient follow through,
- Lack of coordination with specialists,
- Patient fear, and
- Time issues/forgetfulness.

<u>Smoking Cessation:</u>

- Low success rate,
- Time,
- Insurance reimbursement/coverage, and
- Patient attitudes.

Physicians also voiced general concerns about guidelines. These include:

- Skepticism about following guidelines that are developed by "special interest groups,"
- Loss of credibility for guidelines developed by academic physicians due to a lack of practicality,
- Mistrust of the science used to develop guidelines,
- Rapidly changing guidelines that cause physicians to lose credibility with patients,

- Patient demand because of self-education,
- Lack of cost/benefit information on implementation of guidelines,
- Increased costs involved with implementing certain guidelines (e.g., cholesterol screening),
- Lack of acknowledgement that guidelines need to be adapted depending on patient circumstances, and
- Complexity of adhering to guidelines (e.g., diabetes care).

Physicians talked about ways to overcome barriers to implementing best practices. Their discussions focused mainly around the following areas:

- **Improved Office Support:** For mammograms, tools such as automated office reminders and a simple document that summarizes current wait times for getting mammograms at various sites in Rhode Island were useful to physicians.
- **Insurance coverage:** For implementation of some guidelines, insurance may not cover all components of the recommended best practice. For example, tobacco counseling takes time and it is not always adequately covered by insurance. Additionally, some potentially helpful medications, such as Zyban, are not covered by some insurers.
- **Acknowledgment that guidelines alone don't always dictate physicians' decisions:** Physicians integrate guidelines into their practices as one tool out of many that inform their decision making. Other factors that impact their decisions include their schooling, experience, personal views, independent research, and the patient's situation (family history, etc.).
- **Multi-faceted approach to changing patient behavior:** Physicians recognized that smoking quit rates are not due solely to their efforts; although they believe that they have an important role. They acknowledged that community resources such as support groups may be more effective at creating sustained change in smoking behaviors. They also noted that improved patient outcomes are dependent on a multi-faceted approach to behavior change that includes patient education, media campaigns, and legislation.

Most physicians reported that they generally teach best practices to medical students and interns by modeling them with their patients. Some felt that teaching was incorporated into their practices fairly smoothly, while others stated that teaching slowed them down because of the need to talk to the student before and after patient visits. One physician commented that the increased time needed to teach impacts the number of patients that can be seen in a day, thus impacting profitability.

Detailed Findings

Benefits of Best Practices Guidelines

The majority of physicians indicated that they generally find best practices guidelines helpful when they are based on **strong scientific evidence**, when they are **clear,** and when there is **consensus among major professional organizations on the recommendations.** Physicians find guidelines useful for keeping themselves updated on information and for educating and influencing patients.

> *"We are all scientists. When something is proven, we love it. For example, everyone flocked to beta-blockers based on good evidence."*

> *"It helps when there is uniformity of opinion. When opinions are uniform, when there are strong guidelines and there are strong organizations behind it, which will happen when there is consensus, the public hears about it. It is less difficult to convince patients."*

Many physicians noted that there is so much research underway that it is difficult to stay updated on changing recommendations for practices. **Guidelines are a mechanism for staying updated.** They provide physicians with easy access to useful information. They enable physicians to keep track of best practices for treating common illnesses, and to know how to access information on less common diseases.

Several physicians noted that well-developed clinical guidelines from organizations that they respect are helpful. They provide **an overview of current research** so physicians do not have to spend as much time researching issues. They provide confidence that physicians are *"speaking from the force of science."*

Many physicians said they believe that basing their practice on guidelines is important from a liability perspective.

> *"As a practicing physician in the US, it is important to toe the line. I feel exposed to malpractice issue if not following guidelines."*

Several physicians reported that implementing guidelines from a **trusted** source helps them improve the care they provide to their patients. In these cases, motivation to provide good patient care is a driving factor in physicians' use of best practices.

Current Practices

Discussion of physicians' current use of guidelines focused on the use of guidelines for breast cancer screening and tobacco cessation.

Guidelines for Breast Cancer Screening

Current Use of Guidelines for Breast Cancer Screening

All physicians indicated that they are aware of the major guidelines for breast cancer screening. However, they identified specific concerns related to these guidelines and described their own practices in these areas, which are often based on the adaptations to the guidelines.

When asked with which specific breast cancer guidelines they were familiar, physicians said they are aware of screening guidelines, including those developed by the American Cancer Society (ACS), American College of Physicians (ACP), American College of Radiology (ACR) and the United States Preventative Health Services Task Force/Agency for Healthcare Research and Quality (AHRQ).

In their discussion of the breast cancer guidelines, physicians agreed that the guidelines provide consistent recommendations for screening for women over age 50. Prior to age 50, guidelines make varying recommendations in the frequency that women should receive breast cancer screening, while taking into account factors such as family history. Some guidelines recommend screening annually after age 40, while others recommend screening every two years.

When asked what guidelines they specifically implement in their practice, either as a whole or in part, **several physicians in the salaried focus group** mentioned that they have implemented components of guidelines, but with modifications.

> *"I am not sure which I follow; I recommend mammograms annually after age 40."*
>
> *"[I implement] ACP with caveats."*
>
> *"I complete a request slip with the recommendation for the first screening mammogram between age 35 and 40. After 40, I offer it yearly. I tell them that it is controversial when women are in their 40s, that it is based on patient choice but it should be annual or biannual to age 50."*

One physician noted that concern over liability issues makes him more aggressive in following the recommendations.

Several physicians from this group noted that they have a discussion with the patient about their family history for breast cancer. If the patient who is on a biannual cycle for screenings expresses concern because of family history or other potential risk factors, several physicians noted that they would modify their referral pattern to annual.

All physicians in the non-salaried focus group stated that they have implemented guidelines for breast-cancer screening. They noted that patient requests for mammograms and willingness of insurers to cover this service help make adhering to the guidelines possible.

> *"HMOs give report cards based on billing for mammograms. I get notes from an HMO that a patient needs a mammogram. I think that is a good thing."*

"Women ask for them."

"Patients are aware. Cancer statistics are broadly known. Fear is a motivator."

Physicians in both groups noted that guidelines do not provide recommendations for screening later in life, such as after age 75. Physicians expressed interest in knowing what the best frequency is for older patients and at what point it is recommended to start reducing the frequency of mammograms.

Practices varied in terms of how physicians in the groups deal with this issue.

"I tell patients that mammograms are recommended every year. If the patient has qualms, I support the patient's choice if she is resistant. With younger patients, I would push harder if they are resistant. I talk about it longer and try to convince them longer. I feel comfortable offering it to anyone but the discussion varies by the age."

"After 75, screening is controversial. How long to continue it is a patient and doctor discussion. It raises issues about life expectancy. If life expectancy is more than 10 years, I recommend continuing screening."

"Usually what I do is when the patient is 75, I do screening every two years. When the patient is 85, I stop doing screening. My general feeling at that age is that if the patient can't feel it, don't worry about it."

In general, physicians in both groups seemed comfortable with guidelines for women ages 50 through approximately age 75. For women outside this age range, most are familiar with recommendations in the guidelines, but have adapted them based on their own experience, patient preference, and their individual judgments of their patients' needs.

Challenges to Implementing Breast Cancer Screening Guidelines

One major challenge against the use of breast cancer screening guidelines is that the **guidelines developed by different organizations are not consistent.** Several physicians in both groups identified this as a barrier to implementing the guidelines. One physician commented:

"It is controversial depending on who you read. Yearly after 50 is agreed on. It depends on who you are speaking with about recommended frequency in the 40s, unless there was cancer in the family for someone early in life, but then you can argue about what early is."

Another challenge related to breast cancer screening guidelines is that several physicians believe that **there is no strong data linking use of the guidelines to improved health outcomes.** While several physicians noted that use of mammograms resulted in earlier detection of breast cancer, they believe that mammograms may not have an impact on mortality rates for people diagnosed with breast cancer. Others noted that **false positives create unnecessary anxieties.**

One physician presented a different view about the evidence for improved outcomes.

"No one can answer the question about outcomes. ***We need to trust that the evidence is out there and we need to believe that screening does improve morbidity and mortality.*** *It will always be a controversy. …Overall, I think that we are saving lives and adding years."*

Another barrier is patient follow-through for scheduling mammograms. One physician estimated that only two thirds of patients follow through.

One reason that patients may not follow-through is the waiting time for getting an appointment for a mammogram. Several physicians noted that in the past, patients were able to get an appointment in the same day. Currently, physicians report that there can be lengthy waits of up to 180 days. With long waits, it becomes more likely that patients will forget their appointment and will not receive the test.

Lack of coordination with specialists can add confusion about whether mammograms have been ordered. It was noted that a patient's gynecologist is generally the person who orders mammograms. Because a record of the exam may not be sent to the patient's primary care physician, he/she may not be aware of whether a screening has been done. One physician noted that he asks the patient about whether a mammogram has been ordered, whether it has been done, and the results. Two physicians with internal medicine practices with sub-specialties noted that patients might be uncomfortable with having a specialist (such as an internist with a GI subspecialty) order a mammogram. These patients seemed to be more comfortable with breast cancer screening being ordered by their gynecologist.

Other barriers that physicians mentioned include patient fear of experiencing discomfort or pain during the mammogram and **language barriers** for non English speaking patients.

Commercial insurance was noted to <u>not</u> be a barrier to implementing breast cancer screening guidelines. Physicians mentioned that all insurers cover annual screenings and follow-up exams for irregularities. The Rhode Island Department of Health (HEALTH) offers free mammograms for the uninsured, so there is no financial barrier to getting mammograms. Lack of awareness of HEALTH's program, however, may be an issue for eligible people.

Some physicians felt that Medicare can be a barrier because it does not always reimburse physicians for preventative care. According to these physicians, if there is no family history that justifies counseling on mammograms, there is no justification for reimbursement. Some patients may have the resources to self-pay for these services, but more often, physicians say they have to absorb the cost.

A final barrier that was cited was physician forgetfulness. While one physician noted that he is aware of the need to discuss and order mammograms for patients, at times he might forget to hand off the order form at the end of the visit.

How Physicians Deal with these Challenges

Physicians reported that they deal with conflicting guidelines for breast cancer screening in different ways. As described earlier, **several physicians base their practices on a particular guideline with modifications.** Another physician mentioned that:

> *"When three or four organizations develop their own guidelines and send out 'infomercials' about them, in practice you end up settling at the lowest common denominator."*

Several physicians noted that they resolve this conflict by **presenting the various recommendations in the guidelines to the patients and letting them choose.** As part of this process, they discuss issues with patients such as their personal risks.

One physician noted that **a tool provided to her by Rhode Island Quality Partners (RIQP) helped her address the issue of wait times for mammograms.** This tool provides her with information about current wait times for scheduling mammograms at several sites in Rhode Island. She reported that it helps patients schedule appointments at facilities with shorter waiting times, which she believes results in more patients following through with mammograms.

A few physicians noted that discussing breast cancer screening and ordering mammograms are **incorporated into the list of things that need to be covered during a physical exam.** This creates the opportunity to talk about mammograms, to check on whether the patient's gynecologist has ordered it, and, if needed, to ensure that the hand-off of the order is not forgotten. Another physician noted that his **office computer system tracks when a mammogram should be done and generates a trigger for him.** Prior to the implementation of this system, his records were less organized, making it harder to track this issue.

Guidelines for Tobacco Cessation

Current Use of Guidelines for Tobacco Cessation

All physicians indicated that they are aware of the major guidelines for tobacco cessation screening. While they all implement tobacco cessation counseling in their practices, they utilize a range of components from the guidelines without strictly following a full set of guidelines.

Physicians agreed that, unlike breast cancer screening guidelines, **lack of consensus across the guidelines is not an issue for tobacco cessation guidelines.** However, they noted that the processes recommended by the guidelines vary. For example, one physician sited a tobacco cessation guideline from the American College of Chest Physicians, which provides recommendations for behavioral **and** psychopharmacologic interventions, with several alternatives included for each. Other guidelines focus primarily on one or the other.

Several physicians in the non-salaried group felt that there are no useful guidelines for tobacco cessation. However, one physician in the group stated that a useful guideline does exist and physicians should thoroughly know its contents. When asked about how often the guideline has been implemented, this physician noted the following.

"In general, physicians think that they use guidelines all the time but it is probably less than 50 - 60% of the time. Studies show that guidelines are used less than people think."

There was agreement across both groups about the importance of the physician's role in counseling patients to stop smoking. All of the physicians indicated that they have a process which they follow to counsel and assist patients. There was variation in the extent to which they see their process based on a guideline versus a process that they have developed over time. Several physicians described their approaches to counseling patients about tobacco cessation. These which involved a combination of:

- Raising the issue with patients,
- Assessing their willingness to quit,
- Encouraging them to establish a quit date,
- Referring them to resources such as the RI Lung Association,
- Making aids available such as nicotine gum, patches, and medications,
- Identifying cues that cause them to smoke, and
- Helping them make behavior changes to avoid those cues.

Several physicians mentioned that it is important to incorporate smoking into the active problem list in the patient's chart and to monitor it over time.

One physician agreed that bringing up the issue of tobacco use with the patient is the most important component, but that individualizing the approach to the patient is also important.

"The art of medicine is to bring it up appropriately to the individual. You need to show that you understand that it is hard to [quit smoking] but that you are watching them."

Challenges to Implementing Tobacco Cessation Guidelines

A major challenge to implementing tobacco cessation guidelines that several physicians raised is the **low success rate in getting patients to quit smoking and to remain smoke-free.** While guidelines may be helpful to physicians in establishing a process, it was questioned whether they are the factor that will ultimately impact the patient's success.

"Everyone who is a health care provider thinks that smoking is the devil. But even if you follow guidelines, the success rate (for quitting) is low. Even with interventions, you don't get good success rates. Recidivism is incredible, regardless of your approach. You can go through the guidelines and still not be successful. Still I think that I need to do it. I think that legislative changes have the biggest impact, such as limiting the places where people can smoke. This has more impact than counseling."

Physicians said success rates that are low can affect physicians' confidence. While they continue to address the issue with patients, they may feel less successful at working on these issues.

Many physicians said that time is a barrier. Significant time is required for the physician to work with the patient to understand habits such as triggers that can lead to smoking, and to identify

alternative treatments that may work for that patient. One physician noted that following counseling guidelines for breast cancer screening, by comparison, is a much briefer discussion.

Physicians noted that reimbursement for tobacco counseling may be lower than that for types of primary care treatments, even though more time is often needed for tobacco counseling as compared to other treatments.

Physicians said that **when services are available to assist patients in quitting smoking, this ultimately allows him or her to save time.** One physician described a clinic that offered a full range of services, including support groups and clinicians with tobacco cessation expertise. This physician felt that the program was a helpful resource and that her patients were "in good hands" in this program. However, the program has been eliminated so she no longer had access to resources that could help her save time and access specialized services for patients.

Insurance was identified as a barrier. For example, some potentially helpful medications are not covered by insurance or are only covered in limited situations. For example, one physician noted that Zyban is only covered if the patient has a diagnosis of depression. He noted that this puts him in a bind because using the diagnosis of depression in a patient's medical record can have a negative impact for the patient. In addition, if that is not the reason that Zyban is being ordered, the physician feels like he is lying. Insurance may also not cover specific programs that physicians believe can be effective in helping patients quit.

Other issues that physicians noted were related to patient attitudes. First, as an addiction, smoking is a difficult behavior to change. Physicians reported that patients ultimately have to be the ones to initiate the attempt to quit, and this is a difficult process. In addition, some patients cite fears such as gaining weight as barriers to quitting. One physician noted that it is difficult to strike the right balance with patients:

> *"I have a fear of turning the patient off. I want to nag enough but I don't want to be totally intrusive. I want to show them that I care but I want them to come back."*

Many of these barriers underscore the challenges of helping patients deal with complex addictive behaviors. Considerable time is required to assess the patient's needs and to identify the best approach for treatment, in the context of a busy practice.

How Physicians Deal with these Challenges

Despite the concerns that physicians raised about the effectiveness of the treatment guidelines—low quit rates, high recidivism rates, and the extensive time required to deal with this issue in their practices—they all emphasized their strong belief in the importance of tobacco cessation. **They said that they plan to continue to raise the issue with their patients.** While they described different approaches, many of them described ways that they consistently revisit the issue with patients to assess their readiness to quit.

In terms of dealing with patients' difficulty in trying to deal with the addiction, some physicians described how they try to empower patients to take action. This could involve working with the

patient to look for alternative treatments or creating tailored plans for quitting. However, they acknowledge that ultimately, the patient has to initiate the attempt to quit.

Teaching Guidelines

Current Practices

Most physicians in both groups said that the main way they teach guidelines to medical students and interns is **by modeling their use in practice**. Physicians noted that they provide information to students about guidelines similarly to how they provide information to patients. For example, with respect to conflicting recommendations in guidelines about breast cancer screening, several physicians said they share information with students about how recommended practices for women in the age range of 40 to 50 are controversial, and that there is no solid evidence about the impact of breast cancer screening on mortality. These physicians recommend to the student that they educate the patient, offer a referral for a mammogram and then let the patient decide whether she will schedule a mammogram.

Some physicians noted that they have an important role in showing students how guidelines are translated into patient care.

> *"Students see you model the guidelines for them. The tone of voice and your style impacts how successful you are. Students will pick up on those things. Like talking to someone who might not want a mammogram or how to deal with resistant patients."*

> *"With residents, I talk more and describe more. When teaching students, I talk a lot more but clinical practices don't change."*

One physician noted that medical students generally have a good grounding in evidence-based medicine. But he noted that they need encouragement at times to apply this knowledge. Teaching guidelines is an opportunity for physicians to encourage students to think about the science that has evolved into the guideline. In general, physicians said that students generally have more time available to think about these issues, so it is an important time to get a solid grounding in evidence-based medicine.

A few physicians noted that it is important for physicians to teach medical students the need to be empathetic to patients. For example, one physician described how in teaching tobacco cessation guidelines, he encourages the student to listen to the patient while at the same time focusing on how to empower the patient.

One physician noted that while use of guidelines at times has been referred to as "cookbook medicine," he is comfortable telling students who raise this issue that *"...sometimes using a cookbook, you can make a better meal."*

Challenges to Teaching Guidelines

In general, physicians in both groups did not raise many challenges related to teaching guidelines. Some felt that there were no challenges and teaching was incorporated into their practices fairly smoothly.

Some physicians said that teaching has a financial impact on practicing physicians. Teaching activities, including the use of guidelines, slow physicians down because they need to talk to students before, after and during the time that a patient is receiving care. This may have an impact on the number of patients that a physician is able to see and have a direct result on his or her income. This physician noted that there is no reimbursement for teaching activities. A physician in the salaried focus group noted the time pressure that teaching may pose on physicians based at facilities and who have a specific number of patients that they are expected to treat.

In addition, another challenge is the lack of consensus on some guidelines, such as for breast cancer screening. This requires physicians to review more information with students, which can be time-consuming and complex to integrate.

Other Areas of Concern

Physicians raised other concerns about guidelines in general, in addition to discussions of breast cancer screening and tobacco cessation screening.

Several physicians noted that they are often **concerned about who has developed guidelines and what their interests are in the issue.** It is important to know whether the guidelines were peer-reviewed.

Several physicians noted said they are **concerned about guidelines developed by organizations that have a vested interest in the topic that the guidelines address.** This includes pharmaceutical companies or specialty groups that benefit from the implementation of the guidelines.

Physicians expressed different views on the organizations they trust for developing guidelines. One physician noted that she trusts guidelines from organizations that reflect her training, such as the American College of Physicians. A second physician said that he was most comfortable with guidelines developed by experts in the field. Another physician said that she is most comfortable with guidelines developed by national organizations, stating that they are more objective and they represent broader groups of specialists from all over the country. She raised a concern that guidelines by experts in the field can be too aggressive.

Another physician said he believes that some guidelines are developed by academic physicians, who spend very limited time in practice. He believed that there is a "practicality issue," in that guidelines developed by physicians with limited time in practice may be far removed from the challenges that physicians in busy offices face. This makes him question the utility of some of the guidelines.

A few physicians said they are not confident in the science that is used to develop the guidelines. They believe that the guidelines combine ("or smoosh together") many studies with multivariate analysis, and that the experts support the guidelines without adequate evidence.

Another issue is the rapid development of many new guidelines, all of which physicians are then expected to implement. As one physician described it, *"Science is exploding in every realm. For every new guideline, we are told that it will take two minutes to follow it. Sometimes, you cannot add two more minutes."*

Related to the development of new guidelines is the fact that when guidelines change significantly, physicians may feel awkward recommending these to their patients. As an example, one physician noted changes in guidelines related to the use of diuretics. This physician was concerned that when guidelines recommend significant changes in practice, patients may lose faith in their physicians. While the physician can give the patient information about the changes in the guidelines, the concern regarding patient confidence remains.

One physician noted that patients educate themselves on many issues, especially through the Internet. Many patients ask a lot of questions and want to have long discussions on some issues, such as mammograms. These dialogues can use up considerable time in an office visit.

Another concern that was raised is the lack of information that accompanies new guidelines regarding the cost and benefits of implementing them. As an example, one physician said that millions of dollars are spent on mammograms but there is no outcome data that estimates number of lives saved. He felt that this information is important to society in general, and to the physician in terms of how he implements guidelines, but that this trade-off is generally left out of the discussion of new guidelines.

Another physician described how **following guidelines can increase costs.** As an example, he mentioned guidelines for cholesterol screening identify many people who may benefit from using cholesterol-lowering drugs, but of these people, some probably don't have adequate insurance coverage or financial resources to obtain them.

Several physicians also noted that while guidelines are helpful, they often need to be adapted in order to be applicable to the patient. This may be due to patient demands, their age, and the complexity of their medical issues.

The use of guidelines requires physicians to track a number of measures, using diabetes care as an example. This requires tracking information on a potentially large group of patients in a practice, some of who may not be coming in to the office regularly for necessary care. **This issue can be assisted by office systems such as computerized data registries,** but requires financial resources to implement these systems and staff to manage them.

Guidelines for treating patients with multiple illnesses can be complex. In some cases, best practices would dictate that multiple guidelines should be followed, which could be overwhelming for the patient and also for the physician's office in terms of record keeping of all of the measures included in the guidelines.

In general, physicians underscored the large amount of information that they and their practices are required to track. While guidelines may be a useful tool for managing and streamlining patient care, they also create additional demands in terms of information that needs to be tracked and monitored.

Solutions to Assisting Physicians in Implementing Guidelines

Physicians in both focus groups had many suggestions about improvements to guidelines themselves, to the delivery of guidelines, and to ways that their use could be supported.

Content of Guidelines

A clear theme throughout the focus groups was that **physicians need to feel confident in the scientific method used in developing a guideline, as well as the organizations or individuals who developed it.** This suggests the importance of thorough disclosure of who was involved in the development and their affiliations.

It also suggests the importance of providing physicians with a concise overview of the scientific method that was used in developing a guideline.

Physicians noted the importance of providing evidence of the impact that the recommended practice has on patient outcomes. In addition, when possible, physicians expressed an interest in viewing discussion on the social costs of implementing the guideline.

One physician noted that guidelines often combine many recommended practices, but do not necessarily provide enough information on which are evidence based. He felt that it would be helpful to see "tiered" recommendations based on the amount of available scientific evidence. This would allow the physician to evaluate the components that he or she will implement based on the evidence, as well as practicality.

Delivery of Guidelines

Physicians said they were comfortable with the guidelines disseminated by RIQP and HEALTH. RIQP was described as an organization that has a good understanding of the gaps between science and practice. HEALTH was also identified as a trusted organization, although some felt that HEALTH occasionally needs to respond to political pressures or public concern such as the implementation of the meningitis vaccine.

One physician, noting that there are so many guidelines that need to be addressed, felt that RIQP and HEALTH should jointly identify the ten most important guidelines with which physicians can make a difference in their practice. This physician suggested that a joint set of guidelines should be a major focus of information disseminated by these organizations.

There was some variation in how physicians prefer to receive guideline information. Some like receiving information by e-mail. Others prefer getting information by faxing, noting that when things are faxed by HEALTH, it attracts their attention. A few wanted hard copies of documents

they could file away and refer to when necessary. Some also liked accessing information from websites if the information is well organized and up-to-date.

Another issue that was raised was the importance of feedback on performance. On physician noted that an insurer in RI provides feedback to physicians on key measures, which is important information to use in evaluating how their patient care compares to guidelines. Several physicians noted that this type of on-going feedback is very important.

Patient Education

Some physicians stressed the importance of developing **group educational forums or group visits for patients with chronic diseases,** such as group visits for diabetics. The shift away from a one-on-one model would allow significant time savings for physicians, while getting patients the services they need. The implementation of group visits raises issues related to insurance coverage, which would need to be explored.

Many physicians also said that delivering preventive health messages repeatedly through multiple channels is helpful in instituting change. For example, with tobacco, media campaigns and quit lines help to reinforce the quit smoking messages that physicians deliver to their smoking patients at every visit.

Systems and Reimbursement to Support Use of Guidelines

Physicians noted the positive impact that technologies such as data registries have on their ability to track multiple measures. Technology that improves the efficiency of office practices and increases physicians' ability to take a more proactive role in patient care has an important role in supporting the implementation of guidelines.

In addition, **health insurance coverage was raised as a barrier to implementing particular guidelines.** Finding ways to influence insurance decisions related to coverage and to identify covered alternatives will play an important role in encouraging utilization of some best practice guidelines.

A Multi-Faceted Approach

One of the groups stressed the importance of a multi-faceted approach to increasing adherence to guidelines. Physicians acknowledged that there are many things that the physician can do in his or her office, but that they cannot impact this issue alone.

A multi-faceted approach could involve improved office support (such as better electronic charting and other systems changes), increased patient education, and media campaigns addressing certain issues. One physician acknowledged that this requires significant resources. However, many emphasized that added support is needed in order to assist them in implementing guidelines.

Attachment A

Moderator's Focus Group Guide

Introduction
Welcome. Our team is working with RI Department of Health, Brown Medical School and Rhode Island Quality Partners to learn about physician perspectives on benefits of implementing clinical best practices, barriers to implementing best practices and how physicians deal with these barriers, and additional support that could help address these barriers.

Ground Rules

- Turn off cell phones-beepers, or put them on vibrate
- Audio/video taping/ mirror
- Confidentiality (we won't identify anyone by name)
- Candid point of view is essential/No "right" answers/Okay to disagree
- No sidebar discussions/Speak one at a time
- Role of Moderator—unbiased and not an expert

Definitions: For the purpose of this focus group, we will use "best practices" to refer to clinical practices that are evidence-based.

We would like to talk about two specific examples of implementing best practices. First we will talk about breast cancer screening.

1. What best practices guideline(s) are you aware of on breast cancer screening?
- American Cancer Society
- US Preventive Health Service
- Other

2. Has this guideline been implemented as a whole or in part in your practice? Why or why not?

3. What adjustments or accommodations did you make to implement this guideline?

4. How has implementing the guideline helped you in providing patient care?

5. How do you think the guideline has affected patient outcomes?

6. What makes it difficult to implement these guidelines?
    - Not consistent with own personal views and practices
- Complexity of guidelines
- Validity of recommendations
- Insurance coverage issues
- Time to implement

- Lack of sufficiently trained clinical staff to assist me
- Technology needed to implement guidelines is not available in my office
- Referral/follow-up lag
- Patient attitudes
- Patient expectations about level of service
- Patient inconvenienced
- Legal/malpractice concerns
- Not consistent with patient expectations/requests
- Conflicting standards

7. How do you overcome these barriers in your practice?

8. How have best practice guidelines been incorporated into any <u>teaching</u> you do (or have done) with medical students/residents? What are the barriers to teaching these best practices?

9. Now we will talk about best practices surrounding **tobacco cessation**. What best practices guideline(s) are you aware of on smoking cessation?

10. Has this guideline been implemented as a whole or in part in your practice? Why or why not?

11. What adjustments or accommodations did you make to implement this guideline?

12. How has implementing the guideline <u>helped you</u> in providing patient care?

13. How do you think the guideline has affected patient outcomes?

14. What makes it <u>difficult</u> to implement these guidelines?
    - Not consistent with own personal views and practices
- Complexity of guidelines
- Validity of recommendations
- Insurance coverage issues
- Time to implement
- Lack of sufficiently trained clinical staff to assist me
- Technology needed to implement guidelines is not available in my office
- Referral/follow-up lag
- Patient attitudes
- Patient expectations about level of service
- Patient inconvenienced
- Legal/malpractice concerns
- Not consistent with patient expectations/requests
- Conflicting standards

15. How do you overcome these barriers in your practice?

16. How have best practice guidelines on breast cancer screening and tobacco cessation been incorporated into any teaching you do (or have done) with medical students/residents? What are the barriers to teaching these best practices?

Motivation and Support for Implementing/Teaching Best Practices

17. In general, how are best practices helpful in your practice? Not helpful?

18. How do best practices fit in with your views about your profession and your career? What about your personal ideas about what is important in life and work?

19. What motivates you to implement them? What motivates you to teach them?

20. In general, whom do you trust to inform you about best practices?

- Professional organizations (which ones?)
- Public health agencies (federal, state, local?)
- Review of professional journals (which journals?)
- Websites that summarize EBM/best practices (which websites?)
- Conferences (which conferences?)
- Through medical school affiliations
- From Rhode Island Quality Partners

21. What types of information need to be included in order for you to trust/accept information on best practices?
    a. How much background or context do you prefer to get?
    b. How important is it to have an overview of the science behind the recommendation?
    c. What makes you confident in the validity of the best practices?

Overall Barriers and Solutions

22. Are there other barriers to implementing best practices that were not discussed?

23. What would make it easier to apply best practices in your practice?
    - Educational interventions
        - Improved materials on best practices (what would improve them?)
        - Materials for staff on best practices (what materials?)
        - Patient education materials (what materials?)
        - Training or guidance on implementing best practice
        - Mass media campaign
    - Operational interventions
        - Use of reminders/computers

        - Audit/feedback mechanisms
        - Substitution of tasks
        - Multi-professional collaboration
    - Financial interventions
        - Incentives

24. What would help you ensure that residents learn and apply best practices?

Conclusions and thank you.